STATE OF MARYLAND—CERTIFICATE OF DEATH

06861

1. PLACE OF DEATH

County Carroll — Registration Dist. No. 82

Village or City Mt. Airy, Md. — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 13 yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Virgie E. Beatty

(a) Residence: No. Mt. Airy, Md. St., ____ Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: J.E.Beatty

6. DATE OF BIRTH (month, dey, and year): Feb. 8,1876

7. AGE Years	Months	Deys	If LESS than 1 day, ____ hrs. or ____ min.
63	4	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: X

10. Date deceased last worked at this occupation (month and year): ____

11. Total time (years) spent in this occupation: ____

12. BIRTHPLACE (city or town) (State or country): Frederick Co. Md.

FATHER

13. NAME: I.Luther Renn

14. BIRTHPLACE (city or town) (State or country): Maryland

MOTHER

15. MAIDEN NAME: Annie A. Cook

16. BIRTHPLACE (city or town) (State or country): Maryland

17. INFORMANT: Mr. J.E.Beatty (Address) Mt. Airy, Md

18. BURIAL, CREMATION, OR REMOVAL — Place: Pine Grove Cemty Date: July 6, 1939

19. UNDERTAKER: C.M.Waltz (Address) Winfield, Md

20. FILED: July 5, 1939 Thos D Snyder Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July 3,1939 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 20, 1939 to July 3, 1939

I last saw her alive on July 3, 1939; death is said to have occurred on the date stated above, at 6 P m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Angina Pectoris	6/20/39

Other **Contributory Causes** of importence:

Nema of operetion: none Date of ____

Whet test confirmad diagnosis? ____ Was thare en eulopsy? no

23. If deeth was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury ____

Netura of Injury ____

24. Was diseese or injury in any way related to occupetion of deceasad? no

If so, specify ____

(Signed) J. Stanley Grabill M. D.

(Address) Mt. Airy, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED
AUG 7 1928
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

STATE OF MARYLAND—CERTIFICATE OF DEATH 06862

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH

County Carroll (82-0) Registration Dist. No. 78

Village or City Taneytowne No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Samuel Tobias Bishop

(a) Residence: No. Taneytown, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Bishop

6. DATE OF BIRTH (month, day, and year) April 20, 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired farmer

9. Industry or business in which work wes done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked et this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Md. (State or country)

FATHER

13. NAME Henry Bishop

14. BIRTHPLACE (city or town) Md. (State or country)

MOTHER

15. MAIDEN NAME Mary Ohler

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFORMANT Mrs. Margaret Bishop

(Address) Taneytown, Md.

18. BURIAL, CREMATION, OR REMOVAL

Lutheran Taneytown Date July 6, 1939.

19. UNDERTAKER C.O. FUSS & SON

(Address) Taneytown, Md.

20. FILED July 5, 1939 Ethel M Mehring Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 3 (Day), 193 9 (Year)

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

I last saw h alive on , 19 ; deeth is said to heve occurred on the date stated above, at 5 P m.

The PRINCIPAL CAUSE OF DEATH and releted causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	7/3/39.

Other Contributory Causes of Importance:

Neme of operetion None Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If deeth was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did Injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Neture of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Jas. T. Shank Deputy Medical Examiner M. D.

(Address) New Windsor Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED
AUG 2 1930
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(23)

CERTIFICATE OF DEATH

06863

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 10 Mo. 2 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1103 Sharp St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Naomi Black

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): July 25, 1923

8. AGE:

Years	Months	Days	If less than one day
16	0	0	---hrs. ---min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: ---

FATHER
12. Name: Rona Black
13. Birthplace: Ellaville, Georgia

MOTHER
14. Maiden name: Elar Green
15. Birthplace: Ellaville, Georgia

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/39 (month) (day) (year)
Cemetery or crematory: Mount Calvary Cr
Location: a-a-Co Md
18. Funeral director: Isaac L. Brown & Son
Address: 108 W Montgomery St

19. July 25, 1939 (Date rec'd by registrar) Albert R Swankhaus Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1939 19---, at 12.00 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 3, 1938 19--- to July 25, 1939 19---, and that I last saw her alive on July 25, 1939 19---.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1938
Due to: ---
Due to: ---
Other conditions: ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)
Address: Henryton, Maryland Date signed: 7/25/39

RECEIVED
JUL 29 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

06864

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Md. Tuberculosis Sanatorium
Colored Branch,
Stay in hospital or inst. (yrs., or mos., or days) 1 month 14 days
Stay in this community (yrs., or mos., or days) (Same as above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideace of mother)
State Maryland County Kent
City or town Chestertown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ----

3. (a) FULL NAME Sarah Isabelle Blake

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Henry Blake

--- 6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) February 14, 1911

8. AGE:

Years	Months	Days	If less than one day
28	4	24	---hrs. ---min.

9. Birthplace Chestertown, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At home
FATHER 12. Name Westley Harris
13. Birthplace Chestertown, Md.
MOTHER 14. Maiden name Rachel Leger
15. Birthplace Kent Co., Maryland
16. Informant Dr. Reuben Hoffman
Address Henryton, Md.
17. Burial Date thereof 7-11-39
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Chestertown Cemetery
Location Chestertown, Md
18. Funeral director Weer & Son Inc
Address Sykesville Md.
19. 7/8/39 19--- Albert R Swanklow Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1939, at 2.15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24, 1939, to July 8, 1939
and that I last saw her alive on July 8, 1939

Immediate cause of death	Pulmonary Tuberculosis	DURATION
Due to ---		April 1939
Due to ---		
Other conditions ---		

(Include pregnancy within 3 months of death)

Major findings:
Of operations ---
Of autopsy ---

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address Henryton, Md. Date signed 7/8/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH (94a)

06865

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Clara L Bricker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	~~Single~~ Widow

6 (b) Name of husband or wife: Samuel R Bricker

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 28 1857

8. AGE: Years	Months	Days	If less than one day
82	4	28	hrs. min.

9. Birthplace: Maryland (town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: Wm Vaughn

13. Birthplace: Md

MOTHER 14. Maiden name: Marie Baumgardner

15. Birthplace: Md

16. Informant: Wm F Bricker

Address: Taneytown

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Lutheran July 22 1939

Location: Taneytown

18. Funeral director: C O Fuss & Son

Address: Taneytown Md

19. July 22, 1939 (Date rec'd by registrar) Ethel M Mehrer Registrar Local.

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20th 1939, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13th 1939 to July 20th 1939, and that I last saw her alive on July 19th 1939.

	DURATION
Immediate cause of death: Angina Pectoris	7 days
Due to: —	
Due to: —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. M. Benner M.D. M. D. or other

Address: Taney Town Md. Date signed: July 21st 39

RECEIVED
AUG 2 1939
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (I) (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

06866

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County Carroll

City or town Greenmount
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Greenmount Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME David K Brown

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced widower

6 (b) Name of ~~husband~~ or wife May Goorsuch

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 - 1869

8. AGE: Years 70 Months 5 Days 20 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

FATHER
12. Name David K Brown
13. Birthplace Maryland

MOTHER
14. Maiden name Christina Stephan
15. Birthplace Maryland

16. Informant Horace Reese
Address Manchester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28/39 (month) (day) (year)

Cemetery or ~~crematory~~ Greenmount

Location Greenmount Md

18. Funeral director Edw C Tipton
Address Hampstead Md

19. July 26 1939 (Date rec'd by registrar) Mildred S. Hughes (Deputy) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1939, at 1 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1939, to July 26 1939, and that I last saw him alive on July 25 1939.

Immediate cause of death arterio sclerotic heart disease — DURATION 1 year

Due to General Arteriosclerosis — 1 year

Due to

Other conditions Chronic nephritis — 1 yrs
(Include pregnancy within 8 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William R S Denner
M. D. or other

Address Manchester Md Date signed 7/26/39

RECEIVED
AUG 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06867

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 10 Mo. 13 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 168 W. Cross St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William Earl Brown

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Blanche Brown

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): July 14, 1939 8, 1904

8. AGE: Years	Months	Days	If less than one day
35	0	6	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: John Brown
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Lucy Lee
15. Birthplace: Baltimore, Maryland

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/18/39 (month) (day) (year)

Cemetery or crematory: Mt Auburn Cemetery

Location: Balto City

18. Funeral director: Isaac L Brown & Son

Address: 108 W Montgomery St

19. 7/14/39 (Date rec'd by registrar) 19 Albert R Swanborn Deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1939 19 7:30 P.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 31, 1938 19 to July 14, 1939 19, and that I last saw him alive on July 14, 1939 19.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1938

Due to: ---

Due to: ---

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other

Address: Henryton, Maryland Date signed 7/14/39

RECEIVED
JUL 18 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 24

06868

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
Springfield State Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs., 4 mos., 27 days
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Moyer St.,
(If rural give location)
(e) If foreign born, how long in U. S. A.? -----years

3 (a) FULL NAME Henry Buenger

3 (b) If veteran, name war: Not veteran

3 (c) Social Security No. -----

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Unknown

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1870 1876

8. AGE: Years 63 69 | Months 3 | Days 13 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Stationary engineer

11. Industry or business Carlysle Glass Co.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Christina Buenger
15. Birthplace Unknown

16 (a) Informant Springfield State Hospital records.
(b) Address Sykesville, Maryland.

17 (a) Mt. Carmel (Burial, cremation, or removal) (b) Date thereof 7/10/39 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md

18 (a) Funeral director Leonard O Covington
(b) Address 21 W. 25th St

19 (a) 7/7/39 (Date rec'd by registrar) (b) Harry Weer Registrar

MEDICAL CERTIFICATION

20. Date of death July 7th, 1939 at 3:15 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1937, to July 7 1939, and that I last saw him alive on July 6 1939.

Immediate cause of death	Duration
Bronchopneumonia	24 hrs.
Due to ?	
Due to	
Other conditions Cerebral arterio-sclerosis (Include pregnancy within 3 months of death)	Prior to 2/10/37

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ---
(c) Where did injury occur? ---- (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ----- (Specify type of place) While at work?
(e) Means of injury ----

23. Signature Samuel Bartlett M.D. M. D. or other
Address Springfield State Hospital Sykesville, Md Date signed 7/7/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

CHANGE OF AGE: Letter filed July 24, 1939 under

DR. DARLING, Supt. Springfield State Hospital; L.

RECEIVED
JUL 13 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06869

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 9 Mo. 5 Days.

Stay in this community (yrs., or mos., or days) (Same As Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Loveville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Ella Maude Burgess

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Lloyd Burgess (Dead)

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 10, 1896

8. AGE: Years	Months	Days	If less than one day
43	0	22	____ hrs. ____ min.

9. Birthplace Loveville, St. Mary's Co., Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Unknown

FATHER
12. Name Thomas Herbert
13. Birthplace St. Mary's Co., Maryland

MOTHER
14. Maiden name Marie Cutch
15. Birthplace St. Mary's Co., Maryland

16. Informant Dr. Reuben Hoffman

Address Henryton, Maryland

17. Burial Date thereof 7/6/1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph

Location Montgomery Md.

18. Funeral director P. B. Robinson

Address Leonardstown, Md.

19. July 3, 1939 Albert L. Swankhaven
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1939 19____, at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28, 1938 19____, to July 3, 1939 19____, and that I last saw her alive on July 3, 1939 19____.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1937
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? ---
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other

Address Henryton, Maryland Date signed 7/3/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 4 1939
BUREAU V. S.

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 74

107-a

CERTIFICATE OF DEATH

06870

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Sykesville, Md (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Springfield State Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 12 da.

(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 Weaver Lane (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Catherine Kate Carroll

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 24 - 1862

8. AGE: Years 77 | Months 1 | Days 8 | If less than one day _____ hr. _____ min.

9. Birthplace Franklin Town - Md (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name James Carroll
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Brady
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Weaver

(b) Address 2211 Weaver Lane - Hillsdale, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 (month) 6 (day) 39 (year)

(c) Cemetery or crematory Lorraine Cem.

Location Balto. Co. Md.

18 (a) Funeral director G. Howard Strong

(b) Address Lighter & Montgomery Sts.

19 (a) 7/3/39 (Date rec'd by registrar) (b) Harry Weer Registrar

MEDICAL CERTIFICATION

20. Date of death July 2 1939, at 10:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1939, to July 2 1939, and that I last saw him alive on July 2 1939.

Immediate cause of death	Duration
Due to Bronchopneumonia	June 17, 39
Due to	
Other conditions Arteriosclerosis	More than 5 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. Virginia Beyer M. D. or other

Address Sykesville Date signed July 3 1939

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JUL 13 1939
BUREAU V. S.

06871

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:
County: Carroll
City or town: Rural-Near Hampstead Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural, Near Hampstead Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: — White House Rd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Christian Cooper
3. (b) Social Security Number: None —

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Amanda Jane Cooper
6 (c) If alive, give age: 76 years
7. Birth date of deceased (mo., day, yr.): December 7, 1860
8. AGE: Years 78 | Months 7 | Days 10 | If less than one day ___ hrs. ___ min.
9. Birthplace: Middletown, Balto Co, Md.
(Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business: Agriculture
FATHER
12. Name: Joseph Cooper
13. Birthplace: Maryland.
MOTHER
14. Maiden name: Susan Baker
15. Birthplace: Maryland.
16. Informant: Lester C. Cooper
Address: Hampstead, Md.
17. Burial (Burial, ...) Date thereof: July 20-1939 (month) (day) (year)
Cemetery or crematory: Hampstead Md
Location: Hampstead, Md
18. Funeral director: Edw C Tipton
Address: Hampstead Md
19. July 18 1939 (Date rec'd by registrar) Mildred S. Hughes (Deputy) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1939, at 7 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1939, to July 17 1939, and that I last saw him alive on July 16 1939.

Immediate cause of death: Heart Bloc. — DURATION: 2 days
Due to: Arterio-Sclerotic Cardio-Renal vascular — ?
Due to: Disease.
Other conditions: Hypertrophy Prostate — ?
(Include pregnancy within 3 months of death)
Major findings: —
Of operations:
Of autopsy: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: — Date of:
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: Injured at work?

23. SIGNATURE: Joseph E Bush M.D. M. D. or other
Address: Hampstead Md Date signed: 7-17-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 74

06872

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Sykesville (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Springfield State Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 days

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Baltimore City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2608 Gibbons Ave (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME J. Raymond Davis

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. J. Raymond Davis

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) unk

8. AGE: Years 50 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Oilburner heaters

FATHER

12. Name Charles Lee Davis

13. Birthplace Maryland

MOTHER

14. Maiden Name Mary Daniels

15. Birthplace Maryland

16 (a) Informant Dr. J. Leroy Wright

(b) Address Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-39 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Parkville Md.

18 (a) Funeral director Wm Cook

(b) Address 1217 St Paul St. Balto.

19 (a) 7-10-39 (Date rec'd by registrar) (b) C Harry Weer Registrar

MEDICAL CERTIFICATION

20. Date of death July 10 1939, at 7:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1939, to July 10 1939, and that I last saw him alive on July 10 1939.

Immediate cause of death General paresis

Duration 10 mos. known

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M Virginia Beyer M. D. (M. D. or other)

Address Sykesville, Md. Date signed 7-10-39

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 13 1939
BUREAU V. S.

06873

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(23)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tub rculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 2 Mo. 1 day

Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. White Oak
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR --

3. (a) FULL NAME Lewis Basel Ficklin

3. (b) Social Security Number Unknown

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mildred Ficklin

--- 6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1913

8. AGE:

Years	Months	Days	If less than one day
25	8	5	hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Unknown

FATHER
12. Name Strawther Ficklin
13. Birthplace Virginia

MOTHER
14. Maiden name Ville Davenport
15. Birthplace Virginia

16. Informant Dr. Reuben Hoffman

Address Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof Aug 2 1939 (month) (day) (year)

Cemetery or crematory Colesville Md

Location

18. Funeral director Robert L Snouder

Address Rockville Md

19. 7/30/39 19 Albert R Swanhham
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1939 19 9:00 P.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29, 1939 19 to July 30, 1939 19 and that I last saw him alive on July 30, 1939 19

Immediate cause of death Pulmonary Tuberculosis

DURATION Nov. 1938

Due to ---

Due to ---

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations ----

Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other

Address Henryton, Md. Date signed 7/30/39

(M) (I) (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 4 1939
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

06874

1. PLACE OF DEATH

County Carroll Registration Dist. No. 76

Village or City Westminster Md No. E Green St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Baby Girl Fringer

(a) Residence: No. E Green St St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) 7-24-1939

7. AGE Years Months Days Stillborn If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Westminster Md

FATHER

13. NAME Donald Fringer

14. BIRTHPLACE (city or town) (State or country) Westminster Md

MOTHER

15. MAIDEN NAME Hilda Hippenstiel

16. BIRTHPLACE (city or town) (State or country) Pa

17. INFORMANT (Address) Myrtle Fringer Westminster

18. BURIAL, CREMATION, OR REMOVAL

Place Or Premises Date July 24, 1939

19. UNDERTAKER (Address) Mrs. Myrtle Fringer Westminster

20. FILED 7/20, 1939 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 24 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 24, 1939, to July 24, 1939

I last saw her ~~alive~~ dead on July 24, 1939; death is said to have occurred on the date stated above, at 8:00 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Premature (6 mos)

Date of onset

Other Contributory Causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? Obvious Signs Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) W. Glenn Speicher M.D.

(Address) Westminster Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1937*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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AUG 5 1938
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

06875

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town near Westminster R.D. 4
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 1/2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County Adams.

City or town Littlestown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Martha Ann Frack

3. (b) Social Security Number None

4. Sex F

5. Color or race W.

6. (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Jonas Frack.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1844

8. AGE: Years 94 Months 8 Days 7 If less than one day hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Musser
13. Birthplace Pa.

MOTHER
14. Maiden name No information
15. Birthplace " " "

16. Informant Ray Keefer

Address Westminster Md

17. Removal For Burial Date thereof July-26-1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Caramel Cem.

Location Littlestown, Penna.

18. Funeral director J. W. Little + Son

Address Littlestown. PA. Per R.A.L.

19. July 24 1939 O R Fogle
(Date rec'd by registrar) Registrar
Dep. Local Reg

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1939, at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 , to — 19 ,
and that I last saw h alive on — 19 .

Immediate cause of death Arterio-Sclerosis Chronic Nephritis

DURATION 7

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed July 24-39

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

06876

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 2 months 4 days

Stay in this community (yrs., or mos., or days) (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Howard

City or town Ellicott City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. West Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Abraham Fuller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife ---

6(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1880

8. AGE:

Years	Months	Days	If less than one day
49	5	27	---hrs. ---min.

9. Birthplace Ellicott City, Howard Co., Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Unknown

FATHER
12. Name James Fuller
13. Birthplace Ellicott City, Md.

MOTHER
14. Maiden name Rachel Williams
15. Birthplace Ellicott City, Md.

16. Informant Dr. Reuben Hoffman

Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-14-39 (month) (day) (year)

Cemetery or crematory Ellicott City Md

Location Ellicott City Md.

18. Funeral director J C Higinbothom, Jr.

Address Ellicott City Md.

19. 7/5/39 (Date rec'd by registrar) 19 Albert R Stansbury Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1939 19 7:30 P.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1939 19 to July 5, 1939 19, and that I last saw h- im alive on July 5, 1939 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1938
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:

Of operations ---

Of autopsy ---

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of -

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other

Address Henryton, Maryland Date signed 7/5/39

RECEIVED
AUG 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32-a

06877

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 2 months 13 days
Stay in this community (yrs., or mos., or days) (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 917 N. Durham
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Edward Gallaway

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Laine Gallaway
6(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1897

8. AGE: Years	Months	Days	If less than one day
41	7	7	---hrs. ---min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual occupation Longshoreman
11. Industry or business Unknown

FATHER
12. Name Hedrich Gallaway
13. Birthplace South Carolina

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7, 1939 (month) (day) (year)
Cemetery or crematory Baltimore National
Location Baltimore Md.
18. Funeral director Robert B. Gaines
Address 804 W. Caroline St.

19. 7/3/39 (Date rec'd by registrar) Albert A. Swankhorn Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1939 7.05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20, 1939 to July 3, 1939, and that I last saw him alive on July 3, 1939.

Immediate cause of death: Miliary Tuberculosis — DURATION: May 1939
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No Autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 7/3/39

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 8 1939

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06878

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Md. Tuberculosis Sanatorium, Col. Branch

Stay in hospital or inst. (yrs., or mos., or days): 5 Mo. 8 days

Stay in this community (yrs., or mos., or days): asme as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 642 N. Carey St.,

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: John Wesley Gamble

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ----

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): May 19, 1914 1915

8. AGE:

Years	Months	Days	If less than one day
25 24	3 2	12	---hrs. ---min.

9. Birthplace: South Carolina

(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business: Unknown

FATHER

12. Name: John Gamble

13. Birthplace: South Carolina

MOTHER

14. Maiden name: Ella Louise McFadden

15. Birthplace: South Carolina

16. Informant: Reuben Hoffman. M. D.

Address: Henryton, Maryland.

17. Pleasantville Cem (Burial, cremation, or removal. Which?) Date thereof: Aug. 3, 1939 (month) (day) (year)

Cemetery or crematory: Pleasantville (Owings Mills

Location: Md.

18. Funeral director: Charles Hooper

Address: 514 N. Calhoun St

19. 7/31/39 (Date rec'd by registrar) 19---

Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 39, at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 19 39, to July 31, 19 39, and that I last saw him alive on July 31, 19 39.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	Sept
	1938
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: ----

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 7/31/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

CHANGE OF AGE: LETTER FILED 8/9/39 under Dr. Hoffman. - L.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06879

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 29 yrs., 4 mos., 28 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Not known
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John B. Gasnier

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Unknown
6(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE:

Years	Months	Days	If less than one day
73	?	?	____hrs. ____min.

9. Birthplace France
(Town, county, and state)
10. Usual occupation Door keeper
11. Industry or business St. Mary's Seminary, Paca St., Baltimore.
FATHER 12. Name John B. Gasnier
13. Birthplace France
MOTHER 14. Maiden name Elizabeth Lussean
15. Birthplace France
16. Informant Records of Springfield State
Address Hospital, Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1 1939 (month) (day) (year)
Cemetery or crematory Springfield Hosp.
Location Sykesville Md.
18. Funeral director C. H. Keen
Address Sykesville Md.
19. July 31 1939 (Date rec'd by registrar) C. H. Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31st, 1939, 12:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3rd, 1910 to July 31st 1939, and that I last saw him alive on July 31st, 1939.

Immediate cause of death Pulmonary Tuberculosis — DURATION: Prior to Sept., 1938

Due to

Due to

Other conditions Chronic myocarditis — DURATION: Prior to Sept., 1938

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Alan Jackson M.D.
M. D. or other
Address Springfield State Hospital
Date signed 7/31/39

RECEIVED
AUG 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06880

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Bird Hill
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 24 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Bird Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: George D. Gettier

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Rachael A. Brothers

6(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): January 19, 1867

8. AGE: Years	Months	Days	If less than one day
72	6	0	____hrs. ____min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Peter Gettier
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Elizabeth Bittinger
15. Birthplace: Pennsylvania

16. Informant: Mrs. Rachael A. Gettier
Address: Bird Hill, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/21/39 (month) (day) (year)

Cemetery or crematory: Mount Pleasant Cemetery

Location: Gamber, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 7/20 1939 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1939, at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Myocarditis.	2 days
Due to Carcinoma of Prostate	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Jas. J. Marsh Deputy Medical Examiner
M. D. or other
Address: Westminster Md. Date signed: 7/20/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06881

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 10 mo. 18 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1228 Edythe St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Pearl Good

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: Ernest Good
6(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): March 29, 1906

8. AGE:

Years	Months	Days	If less than one day
33	3	19	____ hrs. ____ min.

9. Birthplace: Columbia, South Carolina (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Unknown
FATHER 12. Name: Adam Portee
13. Birthplace: South Carolina
MOTHER 14. Maiden name: Della Richardson
15. Birthplace: South Carolina
16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland
17. (Burial, cremation, or removal. Which?) Burial Date thereof July 21, 1939 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Annie Arundel Co.
18. Funeral director: Mrs. Robert Elliott & Daughter
Address: 1129 N. Caroline St.
19. 7/18/39 19 (Date rec'd by registrar) Albert R. Swinehart Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1939 19 at 12:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 30, 1938 19 to July 18, 1939 19 and that I last saw her alive on July 18, 1939 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1938
Due to: ---
Due to: ---
Other conditions: ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: --
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?):
Means of injury: --- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 7/18/3

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 21 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (942) Reg. Dist. No. 74

06882

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Carroll,
(b) City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Springfield State Hospital,
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 7mo. 5 days,
(e) Length of stay in this community (yrs., mos., or days) Same.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Montgomery,
(c) City or town Silver Springs,
(If outside city or town limits, write RURAL and give town)
(d) Street No. _____ (If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Leo Lawrence Graeves,

3 (b) If veteran, name war

3 (c) Social Security No. Unknown.

4. Sex: Male.

5. Color or race: White.

6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of ~~husband or~~ wife Ada Frances Hull,

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1887.

8. AGE: Years 52. Months 5. Days 2. If less than one day _____ hr. _____ min.

9. Birthplace Silver Springs, Mont. Co., Md.
(Town, county, and state)

10. Usual occupation Plate Printer.

11. Industry or business U.S. Bureau Printing & Engraving.

FATHER
12. Name Louis B. F. Graeves,
13. Birthplace Silver Springs, Md.

MOTHER
14. Maiden Name Rosa Fiddler,
15. Birthplace Silver Springs, Md.

16 (a) Informant Springfield Hospital Records,
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-39 (month) (day) (year)
(c) Cemetery or crematory Wash. Memorial Park
Location District of Columbia

18 (a) Funeral director J. Arthur Walter, Takoma Funeral Home
(b) Address 5-7 Carroll, D. C.

19 (a) 7/3/39 (Date rec'd by registrar) (b) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. Date of death July 3, 1939 at 5:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938, to July 3, 1939, and that I last saw him alive on July 2, 1939.

Immediate cause of death	Duration
Coronary Thrombosis	7-3-39.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry F. Baer, M.D. M. D. or other
Address Sykesville, Md. Date signed 7-3-39.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 17 1939
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06883

93-C

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Charles St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural, Near Sykesville Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Carroll Co. Louisville

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ellen Freeman Hardy

3. (b) Social Security Number ✓

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	colored	widowed

6 (b) Name of husband ~~or wife~~ David E. Hardy

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21st 1871

8. AGE:

Years	Months	Days	If less than one day
68	1	10	hrs. min.

9. Birthplace Kent Co. Md. (Town, county, and state)

10. Usual occupation domestic servant

11. Industry or business

FATHER 12. Name Isaac Freeman

13. Birthplace Md.

MOTHER 14. Maiden name Ellen Smith

15. Birthplace Md.

16. Informant Mrs Esther K. Brown

Address Westminster, Md.

17. Burial (Burial, ~~cremation, or removal~~, Which?) Date thereof 7 3 39 (month) (day) (year)

Cemetery or crematory Pools' Cem.

Location Louisville Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. 7/1 1939 G. Woodward (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1939, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1939, to July 1, 1939, and that I last saw her alive on June 30 1939.

Immediate cause of death Senility

Chronic myocarditis C.W.G.R.

Due to Duration: Not stated.

Due to Arteriosclerosis

Duration: Not stated.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Clifford M. Taylor M.D. M. D. or other

Address Westminster, Md. Date signed July 1, 1939

RECEIVED
AUG 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06884

(131)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 55 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Bessie Viola Harris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: Zacharias M. Harris

6(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): July 17, 1884

8. AGE:

Years	Months	Days	If less than one day
55	0	3	____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: David Martin

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Virginia Morelock

MOTHER — 15. Birthplace: Maryland

16. Informant: Zacharias M. Harris

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/22/39 (month) (day) (year)

Cemetery or crematory: Kriders Lutheran Cem.

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 7/21 (Date rec'd by registrar) 1939 H. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1939, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1939 to July 19 1939, and that I last saw her alive on July 19 1939

Immediate cause of death: Myocardial degeneration & decompensation

Due to: Chronic nephritis & Hypertension

Due to:

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: Several mo.

Jan 1939

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D.

Address: Westminster Md. Date signed: July 20 39

RECEIVED
AUG 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

06885

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 68 Penn. Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 68 Penn. Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Franklin Helm

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of ~~husband or~~ wife Sarah Everhart

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4 - 1872

8. AGE: Years	Months	Days	If less than one day
66	5	2	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer R. W. Crossing

11. Industry or business

FATHER 12. Name Beal Helm

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Ella Radcliff

15. Birthplace Maryland

16. Informant Mrs. Grace E. Warner

Address St. Petersburg, Florida

17. Burial Date thereof July 8-1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rhodes Cemetery

Location Nr. Westminster, Maryland

18. Funeral director H. Bankard & Son

Address Westminster, Maryland

19. 7/7 1939 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th 1939, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1934 to July 6th 1939 and that I last saw ~~him~~ alive on July 6th 1939.

Immediate cause of death	DURATION
(a) Acute Cardiac Dilatation,	3 hrs.
Due to (b) Chronic Myocarditis and Mitral Regurgitation	2 yrs.
Due to (c)	
Other conditions Diabetes	5 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE L. L. Woodward M. D. or other

Address Westminster Md Date signed 7/7/39

RECEIVED
AUG 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

06886

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town New Manchester Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Manchester Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Baby Girl Hesson

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife Infant
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 24, 1939

8. AGE: Years ____ Months ____ Days ____ If less than one day Still born hrs. ____ min.

9. Birthplace New Manchester (Town, county, and state)

10. Usual occupation Carroll County, Md

11. Industry or business

FATHER
12. Name William Milton Hesson
13. Birthplace Westminster Md

MOTHER
14. Maiden name Hilda Romaine Black
15. Birthplace Manchester, Md

16. Informant Hilda Romaine Black
Address Manchester Md

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or ~~crematory~~ Bixlers
Location Bachmans Valley

18. Funeral director Jacob Winks Sons
Address Manchester Md.

19. July 24 1939 Mrs W. R. S. Dennes
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7—24 1939, at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1939, to July 24 1939, and that I last saw ____ alive on ____ 19____

Immediate cause of death	DURATION
Premature Separation of Umbilical Cord	12 hours
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Joseph E. Buckey M. D. or other
Address Hampstead Md Date signed 7-24-39

RECEIVED
AUG 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

06887

CERTIFICATE OF DEATH

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Hampstead
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Hampstead Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Maurice M Holtzman

3. (b) Social Security Number 212-01-8634

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Ft	W	Married

6 (b) Name of husband or wife William E Holtzman

6(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) February 8 - 1897

8. AGE:

Years	Months	Days	If less than one day
42	4	27	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Machine operator

11. Industry or business Sewing Factory

FATHER
12. Name Shellman H Hare
13. Birthplace Maryland

MOTHER
14. Maiden name Rovilla A Hare
15. Birthplace Maryland

16. Informant Rovilla A Hare
Address Hampstead Md

17. Burial Date thereof July 7-1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hampstead Md

Location Hampstead Md

18. Funeral director Edward C Upton

Address Hampstead Md

19. July 6 1939 John S. Hughes, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1939, at 3.45 a. m.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from April 6, 1939 to July 7, 1939 and that I last saw h- w- alive on July 4, 1939

Immediate cause of death Cerebral Hemmorage due to metastasis

DURATION 5 days.

Due to

Due to Carcinoma of Uterus & metastasis

Probably 1 yr.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Biopsy - Carcinoma of Uterus

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE Joseph E. Buck M.D.
M. D. or other

Address Hampstead Md Date signed 7/5/39

RECEIVED
AUG 3 1933
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-C) Reg. Dist. No. 74

CERTIFICATE OF DEATH

06888

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Sykesville (Rural) (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Sykesville
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in this community (yrs., mos., or days) /

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville (Rural) (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** William Ridgway Kelly

3 (b) If veteran, name war /
3 (c) Social Security No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife /

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1857

8. **AGE:** Years 82 | Months 2 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Hilsdale, Balto Co. Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Dairy Farm

FATHER
12. Name George Kelly
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Read
15. Birthplace Maryland

16 (a) Informant Mrs. Wm. Chifley
(b) Address Sykesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 1939 (month) (day) (year)
(c) Cemetery or crematory Old Oakland
Location Oakland Road

18 (a) Funeral director Harry Keen
(b) Address Sykesville Md

19 (a) July 16 1939 (Date rec'd by registrar) (b) Harry Keen Registrar

MEDICAL CERTIFICATION

20. Date of death July 16, 1939, at 3 40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1939, to July 16 1939, and that I last saw him alive on July 15 1939.

Immediate cause of death Myocardial degeneration — Duration 2

Due to Arteriosclerosis — 3

Due to ____

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. E. Martin M. D. or other
Address Randallstown Date signed 7/16/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JUL 22 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06889

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 11 mo. 28 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 317 Central Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Lawrence Barette Males

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Feb. 4, 1912

8. AGE:

Years	Months	Days	If less than one day
27	6	26	---hrs. ---min.

9. Birthplace: Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: Unknown

FATHER
12. Name: Harry V. Males
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Annie Powell
15. Birthplace: Cumberland, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 1-39 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Cumberland, Md
18. Funeral director: Louis Klein Sons
Address: Cumberland Md.

19. 7/30/39 (Date rec'd by registrar) 19 Albert R Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1939 4:00 A.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 3, 1938 19 , to July 30, 1939 19 , and that I last saw h- im alive on July 30, 1939 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1936
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 7/30/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 4 1939
BUREAU V. S.

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(23)

06890

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 10 mo. 9 days.

Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 414 E. Oliver St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Norman Murray

3. (b) Social Security Number Unknown

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife ---

--- 6(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1920

8. AGE: Years	Months	Days	If less than one day
18	10	1	hrs. min.

9. Birthplace Charlotte, North Carolina
(Town, county, and state)

10. Usual occupation C.C.C. Enrollee

11. Industry or business

FATHER
12. Name Norman Murray
13. Birthplace Alabama,

MOTHER
14. Maiden name Louis Yarbow
15. Birthplace Charlotte, N. C.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof 7-27-39 (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location Brooklyn

18. Funeral director Adolphus Halstead

Address 9 & 8 Bond Hill Ave.

19. 7/23/39 19 (Date rec'd by registrar) Albert R Swankhaus Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1939 19 2:00 P.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14, 1938 19, to July 23, 1939, and that I last saw him alive on July 23, 1939 19.

Immediate cause of death Pulmonary Tuberculosis

Due to ---

Due to ---

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations ---

Of autopsy No Autopsy

DURATION May 1938

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Maryland Date signed 7/23/39

RECEIVED
AUG 4 1939
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

06891

1. PLACE OF DEATH (117-00)

County Carroll Registration Dist. No. 71

Village or City Uniontown Dist. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 11 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME James Myers If U. S. Veteran, specify WAR

(a) Residence: No. Westminster Md. R. D. 1 Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah (Bush) Myers

6. DATE OF BIRTH (month, day, and year): March 7, 1865

7. AGE: Years 74 | Months 4 | Days 4 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Retired Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Farm

10. Date deceased last worked at this occupation (month and year): March 1928

11. Total time (years) spent in this occupation: Life

12. BIRTHPLACE (city or town) (State or country): Maryland.

FATHER

13. NAME: Jermiah Myers

14. BIRTHPLACE (city or town) (State or country): Maryland

MOTHER

15. MAIDEN NAME: Alverta Bankert

16. BIRTHPLACE (city or town) (State or country): Maryland.

17. INFORMANT (Address): Mrs James Myers R. D. 1 Westminster, Md.

18. BURIAL, CREMATION, OR REMOVAL: Place Kridlers Cem. near Westminster Date July 14, 1939

19. UNDERTAKER (Address): J. W. Little & Son Littlestown, PA. Per R. A. L.

20. FILED July 14, 1939 Margaret R. Englar Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 11 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 13, 1939, to July 11, 1939

I last saw him alive on July 11, 1939; death is said to have occurred on the date stated above, at 11:55 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Peptic Ulcer

Date of onset

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John J. Stewart M. D.

(Address) Westminster Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 3, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED AUG 3 1927 BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06892

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 11 Mo. 4 days
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Compton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Nichols

3. (b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife ---

6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1907

8. AGE: Years	Months	Days	If less than one day
31	9	29	hrs. min.

9. Birthplace Buckingham Co., Virginia
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Unknown

FATHER
12. Name George Nichols
13. Birthplace Unknown

MOTHER
14. Maiden name Nannie Branch
15. Birthplace Unknown

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July-17-39 (month) (day) (year)
Cemetery or crematory St. Luke's Cemetery
Location Sykesville, Md.

18. Funeral director Weer & Son Inc.
Address Sykesville Md.

19. 7/14/39 19 (Date rec'd by registrar) Albert R Swanbaum Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1939 19 1:45 P.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10, 1938 19 to July 14, 1939 19, and that I last saw h- im -elive on July 14, 1939 19

Immediate cause of death Pulmonary Tuberculosis — DURATION June 1938

Due to ---

Due to ---

Other conditions ---
(Include pregnancy within 3 months of death)

Major findings:
Of operations ---
Of autopsy ---

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---

23. SIGNATURE Reuben Hoffman, M. D.
M. D. or other
Address Henryton, Md. Date signed 7/14/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

06893

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Foetus Ogle

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
?	W	Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 29 - 39

8. AGE: Years — Months — Days — If less than one day — hrs. — min.

Stillborn

9. Birthplace Union Bridge Md

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Paul E. Ogle

13. Birthplace Union Bridge Md

MOTHER 14. Maiden name Rosaline L. Coons

15. Birthplace Glenn Arm Md

16. Informant Rosaline L. Ogle

Address Union Bridge Md

17. — (Burial, cremation, or removal. Which?) Date thereof — (month) (day) (year)

Cemetery or crematory —

Location —

18. Funeral director —

Address

19. Aug 1 1939 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1939, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —

and that I last saw h — alive on — 19 —

Immediate cause of death	DURATION
Stillbirth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Jas. T. Round M.D.

M. D. or other

Address Union Bridge Md Date signed July 29/39

RECEIVED
AUG 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06894

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near New Windsor
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Carroll.
City or town: Rural, New Windsor. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Jordan's Retreat
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Samuel B. Pittenger

3. (b) Social Security Number: No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of ~~husband~~ or wife: Ella Pittenger
6(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): July 14, 1860.

8. AGE: Years: 79 | Months: 0 | Days: 5 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Frederick Co. Maryland.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Levi Pittenger
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Anna E. Houx
15. Birthplace: Maryland.

16. Informant: Mrs. Ella Pittenger
Address: R.D. New Windsor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22, 1939 (month) (day) (year)
Cemetery or crematory: Winters Cemty
Location: near New Windsor, Md

18. Funeral director: C.M. Walter
Address: Winfield, Md

19. July 22 39 (Date rec'd by registrar) Emory L. Bunker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 39, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1938 to July 19 1939 and that I last saw h[illegible] alive on June 16 1939.

Immediate cause of death: Carcinoma of the Prostate

DURATION: 1937

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Dt operations: Carcinomas of Prostate
Yes
Dt autopsy: None done

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jas. T. Thorsch M.D.
Address: New Windsor Md M. D. or other
Date signed: 7-19-39

RECEIVED
AUG 3
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-C)

CERTIFICATE OF DEATH

06895

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Near Taneytown (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural - Near Taneytown Ward No. (If outside city or town limits, write RURAL NEAR, and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Samuel C. Ramsburg

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Widower

B (b) Name of husband or wife: Eve M. Schley

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1880

8. AGE:

Years	Months	Days	If less than one day
59	6	7	hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: C. Thomas Ramsburg; 13. Birthplace: Md

MOTHER — 14. Maiden name: Margaret Clagett; 15. Birthplace: Md

16. Informant: Irvin C. Ramsburg

Address: Taneytown, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof July 24, 1939 (month) (day) (year)

Cemetery or crematory: St. Joseph's

Location: Taneytown, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

1939 July 23 1939 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21st 1939, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20th 1939 to July 21st 1939, and that I last saw him alive on July 20th 1939.

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. M. Benner M.D. M. D. or other

Address: Taneytown Md. Date signed: July 22nd 1939

RECEIVED
AUG 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

06896

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town (Rooks Mill) Wakefield
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Westminster R.D.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 76 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Near New Windsor Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward E. Rook

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name ~~of husband or~~ wife Mary Nicodemus

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15 — 1862

8. AGE: Years	Months	Days	If less than one day
76	9	13	hrs. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name David Rook
13. Birthplace Maryland

MOTHER
14. Maiden name Lucinda Haines
15. Birthplace Maryland

16. Informant Mr Jessie Thoup
Address Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30-1939 (month) (day) (year)

Cemetery or crematory Pipecreek Cemetery

Location Uniontown, Maryland

18. Funeral director H. Bankard & Son
Address Westminster Maryland

19. 7/28 39 L.K. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28th 1939, at 7 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17th 1939, to July 28 1939, and that I last saw him alive on July 26 1939.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION — Several yrs

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L.K. Woodward M. D. or other

Address Westminster, Md. Date signed 7/28/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (165)

CERTIFICATE OF DEATH

06897

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 1 yr., 10 mos., 27 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3707 Overview Road, Baltimore, Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME
Benjamin Roseman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife Single
6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) February 8, 1907

8. AGE: Years	Months	Days	If less than one day
32	5	13	---- hrs. ---- min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Electrician's aide
11. Industry or business Electrician
FATHER 12. Name David Roseman
13. Birthplace Europe
MOTHER 14. Maiden name Celia Seidel
15. Birthplace Europe
16. Informant Records of Springfield State
Address Hospital, Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-25-39 (month) (day) (year)
Cemetery or crematory Herring Run
Location Balto. Md. Philadelphia Rd
18. Funeral director Jack Lewis Jr.
Address 1439 E. Balto St.
19. July 23 1939 (Date rec'd by registrar) C. Harry Steen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Prior to July 21 1939, at ---- M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---- 19---, to ---- 19---,
and that I last saw h--- alive on ---- 19---.

Immediate cause of death	DURATION
Hanging - Suicide	
Due to Mental illness	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Prior to 2:50 pm
Accident, suicide, or homicide Suicide Date of 7-21-39
Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jos. T. Ward Deputy Medical Examiner
M. D. or other
Address New Windsor Md Date signed 7-21-39

RECEIVED
JUL 28 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06898

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 5 mo. 13 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 100 N. Maderia St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: David Lawrence Scott

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Loemay Scott

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): May 4, 1919

8. AGE: Years	Months	Days	If less than one day
20	2	5	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER — 12. Name: Westley Scott

FATHER — 13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Susie Weaver

MOTHER — 15. Birthplace: Virginia

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7 11 39 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Cedar Hill Md.

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantley Ave.

19. 7/9/39 (Date rec'd by registrar) 19 Albert R. Swanborn, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9, 1939 8:10 A.M. 19 ..., et ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26, 1939 19 ..., to July 9, 1939 19 ..., and that I last saw him alive on July 9, 1939 19 ...

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan, 1938

Due to: ---

Due to: ---

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: ---

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other

Address: Henryton, Md. Date signed: 7/9/39

RECEIVED
AUG 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

06899

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Greenmount
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Rear Greenmount Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Ida E. Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6 (b) Name of husband or wife Thomas A Smith
Deceased 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16th 1864

8. AGE:

Years	Months	Days	If less than one day
74	11	4	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Housework
FATHER 12. Name Peter F. Steger
FATHER 13. Birthplace Maryland
MOTHER 14. Maiden name Nancy Harris
MOTHER 15. Birthplace Unknown
16. Informant Mrs William Harris
Address Greenmount Md
17. Burial Date thereof July 22 1939
(Burial, cremation, or removal) Which? (month) (day) (year)
Cemetery or ~~cemetery~~ St. Peter
Location Baltimore Co. Md
18. Funeral director Jacob Wimpis Sons
Address Manchester Md
19. July 21 19 39 Mildred S. Hafer
(Date rec'd by registrar) Registrar
Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 th 1939, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21st 1939 to July 20 1939 and that I last saw h alive on July 20 th 1939

Immediate cause of death Coronary Thrombosis — DURATION 4 hrs
Due to
Due to
Other conditions Arterio Sclerosis — 2 or 3 yrs
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE L M Resh M. D.
M. D. or other
Address Hampstead Md Date signed July 24th 1939

RECEIVED
AUG 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06900

Reg. Dist. No. 7-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 mos.

Stay in this community (yrs., or mos., or days): 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1747 Portship Road, Dundalk
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Joseph Smith

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Susan Bosman

6 (c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): March 19, 1850

8. AGE: Years: 89 | Months: 4 | Days: 11 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Ship carpenter

11. Industry or business: Ship Building

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Files of Springfield State Hosp.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-2-39 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Frederick Road

18. Funeral director: Lilly & Zeiler INC.

Address: 403 S. Wolfe St

19. July 30 1939 (Date rec'd by registrar) C. Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1939, at 3:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1939, to July 30 1939, and that I last saw him alive on July 24 1939.

Immediate cause of death: Coronary Thrombosis — DURATION
Arteriosclerotic Heart Disease — Prior to Admiss.

Due to: Senility

Due to:

Other conditions: Hypertension

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Alan Jacobson
M. D. or other

Address: Springfield State Hosp. Date signed: 7/30/39

RECEIVED
AUG 4 1939
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

06901

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 4 mo. 2 days
Stay in this community (yrs., or mos., or days) (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 24 W. Woodland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Edward Smith

3. (b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Unknown
6(c) If alive, give age ---

7. Birth date of deceased (mo., day, yr.) March 4, 1900

8. AGE:

Years	Months	Days	If less than one day
39	4	3	---hrs. ---min.

9. Birthplace Montgomery Co., Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Unknown

FATHER
12. Name William Smith
13. Birthplace Montgomery Co., Maryland

MOTHER
14. Maiden name Bertie Marcell
15. Birthplace Montgomery Co., Maryland

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11 1939 (month) (day) (year)
Cemetery or crematory Emory Grove
Location Montgomery Co
18. Funeral director Robert L Snouffer
Address Rockville Md

19. 7/7/39 (Date rec'd by registrar) 19 Albert R Swankhaus Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1939 10:25 P.M. 19 ---, at ---M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5, 1939 19 --- to July 7, 1939 19 ---, and that I last saw him alive on July 7, 1939 19 ---

Immediate cause of death Pulmonary Tuberculosis — DURATION Nov. 1938
Due to ---
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 7/7/39

RECEIVED
AUG 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

06902

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Lineboro
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Lineboro

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 3 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Barbara Alice Snyder

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

B (b) Name of husband ~~or wife~~: Frank E. Snyder

6(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): August 8, 1858

8. AGE: Years: 80 Months: 11 Days: — If less than one day: hrs. min.

9. Birthplace: York Co., Pa.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Self

FATHER
12. Name: Isaac Henry
13. Birthplace: York Co., Pa.

MOTHER
14. Maiden name: Mary Am Lynn
15. Birthplace: Virginia

18. Informant: Wm. H. Buchanan

Address: York, Pa. (1645 W. Phila St.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11, 1939 (month) (day) (year)

Cemetery or ~~crematory~~: Greenmount

Location: York, Pa.

18. Funeral director: Jacob Winks Sons

Address: Manchester Md

19. July 8 1939 Mrs. H. R. S. Dennee
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1939, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1939, to July 8 1939, and that I last saw her alive on July 6 1939.

Immediate cause of death: Diabetes mellitus — DURATION: 10 yrs

Due to:

Due to:

Other conditions: Arterio sclerosis — 10 yrs
Gangrene — 1 wk.
(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. R. S. Dennee M. D. or other

Address: Manchester Md Date signed:

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1939
BUREAU V. S.

06903

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(23)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 2 Yrs. 5 Mo. 6 days

Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 48 Laskins St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Pauline Spencer

3. (b) Social Security Number Unknown

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1917

8. AGE: Years 22 | Months 5 | Days 29 | If less than one day ___ hrs. ___ min.

9. Birthplace Annapolis, Maryland
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Unknown

FATHER
12. Name William Spencer
13. Birthplace Annapolis, Maryland

MOTHER
14. Maiden name Mary Jennings
15. Birthplace Annapolis, Maryland

16. Informant Dr. Reuben Hoffman

Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-25-39 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location A. A. Co.

18. Funeral director Chas. E. Hicks Jr.

Address Annapolis Md.

19. 7/21/39 (Date rec'd by registrar) 19 Albert R. Swankhaus Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1939 4:20 A.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15, 1937 19 , to July 21, 1939 19 , and that I last saw her alive on July 21, 1939 19 .

Immediate cause of death: Pulmonary Tuberculosis

Due to ---

Due to ---

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations ---

Of autopsy No Autopsy

DURATION: Sept. 1936

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide --- Date of --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Maryland Date signed 7/21/39

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(182)

06904

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Marriottsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Goodrich Thomas

3. (b) Social Security Number 219-07-495-8

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8 1912

8. AGE:

Years	Months	Days	If less than one day
27	5	28	hrs. min.

9. Birthplace Howard County Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Charles Thomas
13. Birthplace Howard Co.
MOTHER 14. Maiden name Brenda Griffin
15. Birthplace Howard Co.
16. Informant Martha Lewis (Sister)
Address Hampstead, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/9/39 (month) (day) (year)
Cemetery or crematory West Liberty
Location West Liberty, Md.
18. Funeral director H. C. Hesselbrook Jr.
Address Eldersburg, Md.
19. July 6 19 39 (Date rec'd by registrar) Albert R. Swanckhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 19 39, at 8 45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h alive on ____ 19__.

Immediate cause of death	DURATION
Traumatic Asphyxiation	
Due to Cave in of side 7 16 ft. trench in which he was working.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of July 6-39
Where did injury occur Hampstead (City or town) Carroll (County) Md. (State)
Injured at home, farm, industry, public place (where?) Hampstead Md. Farm
Means of injury Cave in ditch Injured at work? yes

23. SIGNATURE J. J. Shand Deputy Medical Examiner
M. D. or other
Address New Windsor Md Date signed 7/6/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 13 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06905

(23)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or Inst. (yrs., or mos., or days): 4 mo. 6 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 548 Moore St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ernest Thompson

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: -- years ---

7. Birth date of deceased (mo., day, yr.): Jan. 4, 1901

8. AGE:

Years	Months	Days	If less than one day
38	6	7	---hrs. ---min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER — 12. Name: Walter Thompson

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 (month) 13 (day) 39 (year)

Cemetery or crematory: Mangul

Location:

18. Funeral director: Mrs. S. T. Hensley

Address: Mon 578 W. Biddle St

19. 7/11/39 (Date rec'd by registrar) 19 Albert R. Sandbower Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1939 19 , at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5, 1939 19 , to July 11, 1939 19 , and that I last saw h im alive on July 11, 1939 19 .

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1939

Due to: ---

Due to: ---

Other conditions: ---
(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of:

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)

Address: Henryton, Md. Date signed 7/11/39

RECEIVED
AUG 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (77) Reg. Dist. No. 74

CERTIFICATE OF DEATH

06906

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Carroll.
(b) City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Springfield State Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 11 mos. 9 days.
(e) Length of stay in this community (yrs., mos., or days) Same.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3918 Fernhill Avenue.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME William Edward Warner.

3 (b) If veteran, name war

3 (c) Social Security No. Unk.

4. Sex Male.

5. Color or race White.

6 (a) Single, married, widowed, or divorced. Separated.

6 (b) Name of husband or wife Emma E. Allaman.

6. (c) If alive, give age Unk. years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1870.

8. AGE: Years 68. Months 7. Days 27. If less than one day ____hr. ____min.

9. Birthplace Ohio.
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Wood-working Machinery.

FATHER
12. Name Edward (?) Warner.
13. Birthplace U. S.

MOTHER
14. Maiden Name Elizabeth Womboldt
15. Birthplace Ohio.

16 (a) Informant Springfield Hospital Records.
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 1939 (month) (day) (year)
(c) Cemetery or crematory Springfield Hosp. Cem.
Location Sykesville Md.

18 (a) Funeral director E. A. Keen
(b) Address Sykesville Md.

19 (a) July 7 1939 (Date rec'd by registrar) (b) Harry Keen Registrar

MEDICAL CERTIFICATION

20. Date of death July 1, 1939, at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938, to July 1, 1939; and that I last saw him alive on July 1, 1939.

Immediate cause of death	Duration
Cerebral Arteriosclerosis prior to 7-22-37.	
Due to	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry F. Baer, M.D. (M. D. or other)
Address Sykesville, Md. Date signed 7-1-39.

RECEIVED
AUG 4 1939
BUREAU V. S.

06907

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Carroll (87-C) Registration Dist. No. 72.

Village or City Myers Dist. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. - mos. - ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Frances Weaver Weaver If U. S. Veteran, specify WAR

(a) Residence: No. Westminster Md. R.D. 1 Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of → Edward J. Weaver

6. DATE OF BIRTH (month, day, and year): May-4-1863

7. AGE: Years 76 | Months 2 | Days 23 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: House-Wife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Home

10. Date deceased last worked at this occupation (month and year): Jan. 1939

11. Total time (years) spent in this occupation: Life

12. BIRTHPLACE (city or town) (State or country): Maryland.

FATHER

13. NAME: Samuel Stonesifer

14. BIRTHPLACE (city or town) (State or country): Maryland.

MOTHER

15. MAIDEN NAME: Catherine Speck.

16. BIRTHPLACE (city or town) (State or country): Maryland.

17. INFORMANT (Address): Edward J. Weaver Westminster Md. R.D.

18. BURIAL, CREMATION, OR REMOVAL Place: Union Mills Md. Date: July 30, 1939

19. UNDERTAKER (Address): J. W. Little & Son. Littlestown. Pa. Per R.A.L.

20. FILED July 28, 1939. Calvin E. Bankert, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 27 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 29, 1939, to July 26, 1939. I last saw her alive on July 26, 1939; death is said to have occurred on the date stated above, at 12:30 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Paralysis, due to Parkinsons disease. C.W.G.R.

No evidence of cerebral hemorrhage.

Date of onset

Other Contributory Causes of Importance:

Large decubitus ulcer.

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) E. Reese Wilkens M.D.

(Address) Westminster, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

06908

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 7 yrs., 2 mos., 6 days.
Stay in this community (yrs., or mos., or days) same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Howard.
City or town Ellicott City. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George F. Widerman.

3. (b) Social Security Number

4. Sex: Male.
5. Color or race: White.
6. (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 27, 1856.
8. AGE: Years 82 Months 9. Days 25. If less than one day hrs. min.
9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual occupation Farmer.
11. Industry or business
FATHER 12. Name George Widerman.
13. Birthplace Baltimore Co., Md.
MOTHER 14. Maiden name Asenith Shipley,
15. Birthplace Baltimore Co., Md.
16. Informant Springfield Hospital Records,
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 25 1939 (month) (day) (year)
Cemetery or crematory Mt. Olive)
Location Liberty Road - Old Court Road.
18. Funeral director F.C. Higinbothom, D.
Address Ellicott City Md.
19. July 27 1939 (Date rec'd by registrar) Harry Beer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1939, at 6:40 P.M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938, to July 22, 1939, and that I last saw him alive on July 22, 1939.

Immediate cause of death Cerebral Arteriosclerosis prior to 5-16-32. — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D., M. D. or other
Address Sykesville, Md. Date signed 7-22-39.

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BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

06909

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County Carroll — Registration Dist. No. 76

Village or City Medford — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Baby Boy Williams — If U. S. Veteran, specify WAR ____

(a) Residence: No. Medford St., ____ Ward. (Usual place of abode) — If nonresident give city or town and State ____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	Col.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) July 8 - 1939

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
Stillborn			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. ____

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. ____

10. Date deceased last worked at this occupation (month and year) ____

11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) Md. (State or country)

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) ____ (State or country)

MOTHER

15. MAIDEN NAME Elsie May Squirrell

16. BIRTHPLACE (city or town) Medford (State or country) Md.

17. INFORMANT Effie Squirrell (Address) Westminster Md Route 5

18. BURIAL, CREMATION, OR REMOVAL Place Pleasant Hill Cemetery Date 7/9, 1939

19. UNDERTAKER Eric Squirrell (Address) Westminster Md

20. FILED 7/9, 1939 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 8 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____

I last saw h____ alive on ____, 19____; death is said to have occurred on the date stated above, at 7-36 a. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Intrauterine Asphyxia	

Other Contributory Causes of importance:

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? None Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. ____

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) Jas. J. Hood Deputy Medical Examiner M. D.

(Address) Westminster Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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AUG 5 1939
PUBLIC H. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

STATE OF MARYLAND—CERTIFICATE OF DEATH

06910

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH (82a)

County Carroll — Registration Dist. No. 70

Village or City Harney (Taneytown Dist) No. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U.S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Louise Elizabeth Healy — If U. S. Veteran, specify WAR —

(a) Residence: No Taneytown, Md. R.D. St., — Ward. —

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) Dec. 27-1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	6	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House-Work

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Home

10. Date deceased last worked at this occupation (month and year) July-19-1939

11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (city or town) — (State or country) Pennsylvania

FATHER

13. NAME Jacob Healy

14. BIRTHPLACE (city or town) — (State or country) Germany

MOTHER

15. MAIDEN NAME Maria Nubefe

16. BIRTHPLACE (city or town) — (State or country) Pennsylvania

17. INFORMANT Enoch Healy

(Address) Taneytown, Md. R.D.

18. BURIAL, CREMATION, OR REMOVAL

Place St Johns Cem Littlestown, Pa. Date July 24, 1939

19. UNDERTAKER J. W. Little & Son per

(Address) Littlestown, Penna. R.F.D.

20. FILED July 22, 1939 Mary E. Wilt Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 21st (Day) 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 19, 1939, to July 21, 1939

I last saw her alive on July 21, 1939; death is said to have occurred on the date stated above, at 5:10 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	7/20/39

Other Contributory Causes of importance:

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury —, 19—

Where did injury occur? — (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify —

(Signed) Francis D. Elliot M. D.

(Address) Taneytown, Md.

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RECEIVED
AUG 2 1933
BUREAU V. S.

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN